UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

COMMUNITY HEALTH AND COUNSELING SERVICES, Plaintiff	)	
v.	)	Civil No. 99-185-B-C
DONNA E. SHALALA, Secretary of the U.S. Department of Health and Human Services, et al., Defendants	)	

RECOMMENDED DECISION ON CROSS MOTIONS FOR SUMMARY JUDGMENT

Plaintiff, Community Health and Counseling Services (CHCS), a provider of home health services under the Medicare program, seeks judicial review, pursuant to 42 U.S.C. ' 1395oo(f)(1), of Defendants= decision to provide Medicare reimbursement in an amount less than that requested by CHCS for fiscal years 1991, 1992 and 1993. CHCS asks this court to find as a matter of law that for the fiscal years at issue, it fully complied with the federal regulations and rules and that Defendants= decision to reduce the amount of reimbursement requested by Plaintiff was arbitrary and capricious. In opposition to Plaintiff=s motion Defendants filed a motion for Summary Judgment asking the Court to affirm its decision that Plaintiff=s cost-finding methods improperly cross-subsidized non-reimbursable costs to reimbursable costs. For reasons explained below, I recommend that the Court GRANT Defendants= Motion for Summary Judgment and DENY Plaintiff=s Motion for Summary Judgment.

Summary Judgment Standard

Summary judgment is appropriate only if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). "A material fact is one which has the 'potential to affect the outcome of the suit under applicable law.'" *FDIC v. Anchor Properties*, 13 F.3d 27, 30 (1st Cir. 1994) (quoting *Nereida-Gonzalez v. Tirado-Delgado*, 990 F.2d 701, 703 (1st Cir. 1993)). The Court views the record on summary judgment in the light most favorable to the nonmovant. *Levy v. FDIC*, 7 F.3d 1054, 1056 (1st Cir. 1993).

However, summary judgment is appropriate "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Once the moving party has presented evidence of the absence of a genuine issue, the nonmoving party must respond by "placing at least one material fact in dispute." *Anchor Properties*, 13 F.3d at 30 (citing *Darr v. Muratore*, 8 F.3d 854, 859 (1st Cir. 1993)).

Statutory and Regulatory Background

Medicare is a federal program that provides health services to eligible persons. Medicare consists of two parts. Part A provides coverage for eligible persons who need inpatient hospital and post-hospital care, home health services care and hospice care. 42 U.S.C. ' 1395c. Part B is a voluntary supplemental health care insurance program that provides payment to physicians and to other health care services. 42 U.S.C. ' 1395j. In this case, CHCS seeks reimbursement for services it provided under Part A of the Medicare program.

While the statute empowers the Secretary of Health and Human Services (the Secretary) to determine the amount of reimbursement a provider of services under Medicare can receive, 42 U.S.C. ' 1395g, the Secretary may designate a fiscal intermediary, often a private insurance company, to, among other things, determine the amount of reimbursement due to the provider. 42 U.S.C. ' 1395h. During the fiscal years at issue here, the statute directed providers to be reimbursed for Medicare services on a Areasonable cost basis@. 42 U.S.C. ' 1395f(b). The statute defines the Areasonable cost@ of services as the Acost actually incurred@ and that that cost Ashall be determined in accordance with regulations establishing the method or methods to be used . . . .@ 42 U.S.C. ' 1395x (v)(1)(A). The statute continues:

> Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, *may provide for using different methods in different circumstances*, may provide for the use of estimates of costs of particular items or services[,] may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title . . . .

Id. (emphasis added).

As directed by the statute, the Secretary enacted regulations that delineated the cost finding methods a provider should use to determine the reasonable cost of Medicare services. 42 C.F.R. ' 413.24. To edify intermediaries and others in interpreting the Medicare statute and regulations the Health Care Financing Administration (HCFA) publishes the Provider Reimbursement Manual (PRM). The PRM contains the HCFA=s interpretation of the Medicare statute and regulations to assist intermediaries and providers. While the PRM is a Aprotypical example of an interpretive rule . . . [i]nterpretive rules do not require notice and comment.@ *Shalala v. Guernsey Mem=l*

Hosp., 514 U.S. 87, 99 (1995). Further, interpretive rules Ado not have the force and effect of law and are not accorded that weight in the adjudicatory process.@ *Id.*

The regulations promulgated by the Secretary require home health agencies, like CHCS, to use the step-down method to calculate the amount of reimbursement due for services rendered under the Medicare program. The regulations describe the method in detail:

> Step-down Method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

42 C.F.R. ' 413.24. As one court noted this intricate method basically Aaccounts for overhead costs on overhead.@ *Butler Hospital v. Sullivan*, No. 88-0105, 88-0531, 1989 WL 119414 at *2 (D.R.I. Apr. 21, 1989).

The PRM defines the Acenters@ or Ageneral cost service centers@ described in 42 C.F.R. '413.24 as Aorganizational units which are operated for the benefit of the institution as a whole.@ PRM ' 2302.9. The PRM directs that general service costs be allocated to other cost centers using the step-down process:

> The costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. This allocation process is usually made, for Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center.

PRM ' 2307. The PRM also directs that depreciation on buildings and fixtures, interest, rent and other capital costs be combined into a single capital cost center and then be allocated to other cost centers on the basis of square feet occupied. PRM ' 1709.

Each year the provider must file a cost report with the intermediary indicating the costs it considers to be reimbursable under Medicare. 42 C.F.R. 413.24(f). The intermediary reviews or audits the report and issues a Notice of Program Reimbursement (NPR). The NPR contains those costs the intermediary determines the provider is entitled to under the program.

Procedural and Factual Background

CHCS operates a Medicare-certified home health agency (HHA) and several other facilities that do not provide services under Medicare. In all, Plaintiff owns twenty-seven buildings in four counties in Maine.[1] (A.R. 115, 144-45). In accordance with the regulations, CHCS submitted cost reports to its fiscal intermediary, Associated Hospital Service of Maine d/b/a Blue Cross and Blue Shield of Maine (AHSM). In its reports for years 1991, 1992, and 1993, CHCS placed its capital-related costs in a single administrative and general cost center (A&G cost center). Plaintiff then stepped-downed those costs to its general service cost centers and revenue-producing cost centers based on the square footage of building space those reimbursable services occupied.

In addition to its capital costs, CHCS placed costs associated with its common areas (e.g. bathrooms, hallways, and staircases) into an A&G cost center. These costs were then stepped-down to determine the amount of reimbursable costs based on the net accumulated costs (salaries) of those common areas.

[1] Those facilities include a gift shop, a bottle redemption center, a mental health facility, outpatient clinics, a mental health facility, and a hospice center.

AHSM audited the reports submitted by CHCS and issued NPRs that adjusted the manner in which CHCS calculated its capital costs and common area costs. AHSM determined that by placing its capital costs in a single cost center CHCS sought Medicare reimbursement for non-reimbursable costs. AHSM eliminated this problem by placing those buildings that did not perform any reimbursable services in one cost center and placing those buildings that performed some home health agency activities in a separate cost center.

AHSM also determined that CHCS impermissibly shifted non-Medicare costs to Medicare by placing costs associated with its common areas into an A&G cost center. AHSM remedied this by removing the common area costs from the A&G center and using the net method to calculate those costs. This method basically assigns the costs of maintaining the common area to each building in which the common area exists based on square footage.

The Provider Reimbursement Review Board (PRRB) affirmed the method AHSM employed in calculating CHCS=s reimbursable capital costs and common area costs. The Secretary declined to review the PRRB decision and CHCS then filed their Complaint in this action seeking judicial review of the decision. 42 U.S.C. ' 1395oo(f)(1).

Standard of Review

The starting point for judicial review of an agency=s decision is the statute itself. *Chevron U.S.A. Inc., v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1986). If Congress speaks directly to the question before the Court, the Court must give effect to the express intent of Congress. *Id.* However, when the statute at issue is silent or ambiguous with respect to the issue before the Court, the Court must review the agency=s construction of the statute to determine whether the agency=s interpretation of the statute is reasonable. *Id.*

Section 1395oo(f)(1) sets forth the applicable standard of review by incorporating the standards specified in the Administrative Procedure Act (APA). 5 U.S.C. ' 706. Under section 706, a court may set aside the Secretary=s decision if the decision was, Aarbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.@ 5 U.S.C. ' 706(2)(A). This standard is highly deferential to the agency and demands the court to give Aconsiderable weight@ to the agency=s interpretation of the statute. *Chevron*, 467 U.S. at 844. Courts have routinely deferred to the agency=s interpretation when analyzing the statutes that enable the Medicare/Medicaid program. *Cheshire Hosp. v. New Hampshire-Vermont Hosp. Serv.*, 689 F.2d 1112, 1117 (1st Cir. 1982); *DeJesus v. Perales*, 770 F.2d 316, 327 (2nd Cir. 1985) (Acourts must exhibit particular deference to the Secretary=s position with respect to legislation as intricate as [Medicaid]@). When reviewing the agency=s interpretation, the Court is not examining whether the agency=s interpretation is correct, the Court is only determining whether the agency=s interpretation is reasonable. *Little Co. of Mary Hosp. & Health Care Ctrs. v. Shalala*, 994 F. Supp. 950, 953 (N.D. Ill. 1998).

Analysis

A. Capital Related Costs

CHCS first argues that ASHM=s creation of separate cost centers for CHCS=s capital-related costs violates section 1709 of the PRM. Section 1709 permits the provider to either collect capital costs in a single A&G cost center, or report capital costs in separate cost centers for each building. CHCS maintains that section 1709 permits only the provider, and not the intermediary, the option of making the choice. CHCS argues that once it chose to collect capital costs in a single cost center the intermediary was powerless to alter that choice.

As stated above, when Congress designed Medicare it stated that a provider of Medicare services should be reimbursed for the reasonable costs of those services. The Secretary has executed this principle by refusing reimbursement when a provider cross-subsidizes, or attempts to seek Medicare payments for non-Medicare services. Here, Defendant argues that CHCS is cross-subsidizing its services by accumulating its capital costs in a single cost center and then, using the step-down process, prorating those costs to its general service cost centers and to its reimbursable and non-reimbursable revenue producing areas on a square footage basis. Because the price per square foot of those buildings used to calculate the costs rendered were more expensive than the buildings in which Medicare-reimbursable HHA=s services were rendered, the amount CHCS sought reimbursement for on its cost report was greater than the actual Medicare costs it incurred.

AHSM eliminated this problem by placing those buildings that did not perform any reimbursable services in one cost center and placing those buildings that performed some home health agency activities in a separate cost center. CHCS does not dispute that the method it followed resulted in it receiving a greater share of Medicare costs than it actually expended. Instead, CHCS argues that it merely followed the PRM and that AHSM and the Defendants were powerless to change it. I disagree. Even if I assume CHCS did follow the PRM and applicable regulations when it completed its cost reports, that is no reason for Defendants to ignore their statutory obligation to ensure that a provider receive reimbursement for the reasonable cost of Medicare services it dispenses. Certainly the Secretary has not done so in the past. *See Druid Hills Nursing Home*, CCH Medicare and Medicaid Guide &32,440 (PRRB Dec. No. 83-D34, Feb. 18, 1983) (PRRB refused to follow a PRM section that, if followed, would have resulted in cross-subsidizdation). In fact, courts have recognized the importance of the statutory mandate against cross-subsidization when analyzing regulations promulgated by the Secretary. *See Howard*

Univ. v. Bowen, 1988 WL 33508, *2 (D.D.C. Mar. 29, 1988) (construing regulation differently so that it did not violate the statutory mandate that Medicare pay for only the reasonable cost of the rendered services); *Providence Hosp. of Toppennish v. Shalala*, 52 F.3d 213, 218-19 (9th Cir. 1995) (stating that while the Secretary has broad discretion to Adevelop methods of determining costs . . . such discretion is limited by the mandate that the Secretary prevent cross-subsidization.@) Here, it was not an unreasonable application of the law for Defendant to utilize a different accounting method to prevent CHCS from receiving Medicare funds beyond the amount of Medicare services it provided.

CHCS next argues that even if the intermediary or the Secretary can deviate from the collecting method in Section 1709, Section 2308 of the PRM requires a HHA to use the step-down method. Plaintiff then argues that the method employed by AHSM and affirmed by the Secretary is inconsistent with the step-down process. To put it simply, I fail to see how the method employed in collecting costs prior to applying the step-down method compromises the step-down method. What changed is not the use of the method, but how costs are collected prior to applying the method. That is not a violation of Section 2308.[2]

B. Common Area Costs

[2] CHCS argues that the intermediary exceeded its regulatory authority by using a Amore sophisticated method@ of cost-finding. *The Sheppard & Enoch Pratt Hospital v. Blue Cross & Blue Shield Assoc./Blue Cross of Maryland*, HCFA Admin. Dec., Mar. 8, 1984, *aff=d* PRRB Dec. No. 84-D16. However, as stated above, I am satisfied that Defendant employed the step-down method and therefore did not use a Amore sophisticated method@ of cost-finding.

In its cost reports, CHCS placed its overhead common space costs into an A&G cost center, and then allocated those costs to revenue-producing areas, such as the HHA, based on salaries paid to those areas. Again, CHCS does not dispute that the method it followed resulted in it receiving a greater share of Medicare costs than it actually expended. Instead, it contends that the Court should reverse the manner in which AHSM calculated the common area costs because the method used violates the mandatory use of the step-down method to allocate HHA costs.

Defendants argue that because salaries paid for HHA services accounted for thirty-seven percent of CHCS=s overall salary costs, while the HHA only occupied about nine percent of overall common space at CHCS, CHCS assigned higher costs to those common areas than it actually incurred. Defendants maintain that AHSM appropriately remedied this disparity by removing the common area costs from the A&G cost center and using the net method to calculate the amount of those costs in each building. Under the net method the common space areas of a building are eliminated from the total square footage of a building. The costs of the common areas are then included in the overall costs of the building. The space costs of the building are then stepped-down to the general service cost centers and revenue producing areas based on square footage. Applying this method resulted in CHCS receiving about nine percent reimbursement for its common space costs.

I am satisfied that the net method applied by AHSM and approved by the Secretary is not arbitrary, capricious, or an unreasonable application of the law and, in fact, follows the statutory directive against cross-subsidization. It is undisputed that the net method applied by AHSM and approved by the PRRB accurately reflects the actual amounts of costs incurred by CHCS. CHCS asks me to ignore that fact and determine that Athe rules are the rules@ no matter that the application of those rules would directly contradict the statutory directive that a provider be reimbursed for

the reasonable cost of Medicare services it dispenses. However, even the Secretary=s broad discretion to apply cost methods is limited by the statute=s reasonable cost mandate. *See Providence Hosp. of Toppennish*, 52 F.3d at 218-19.[3] Accordingly, I find that the method used by the Defendants in determining the common area costs was not an unreasonable application of the law.

[3] Plaintiff also argues that the method used by Defendants in calculating the common area costs violates the Aaveraging principle.@ *See Doctors Hospital, Inc. v. Blue Cross and Blue Shield Assoc./Blue Cross of Louisiana*, PRRB Dec. 85-D9 (1984). Plaintiff has cited no authority that the Aaveraging principle@ requires the Secretary to violate the statutory directive that Medicare pay for only those reasonable costs associated with providing Medicare services.

C. Alleged Agreement Between CHCS and Defendant

CHCS next alleges that it and the intermediary had reached an agreement in the early 1980=s that CHCS should calculate common area costs using the method it used for the fiscal reports at issue in this case. While no written agreement exists, CHCS points to letters exchanged between it and the intermediary and notes made by the intermediary representative which suggest that the intermediary directed CHCS to collect common area costs in the A&G cost center. Even if I assumed that the evidence that CHCS has produced establishes that an agreement did exist, Athe Government is not estopped by its intermediary=s actions.@ *Sullivan*, 1989 WL 119414 at *2 (citing *Heckler v. Community Health Serv. Of Crawford County, Inc.*, 467 U.S. 51, 63-66 (1984); *Samaritan Health Serv. v. Heckler*, 619 F. Supp. 713, 719 (D.D.C. 1985), *rev=d on other grounds*, 811 F. 2d 1524 (D.D.C. Cir. 1987)). Therefore, any agreement between CHCS and the intermediary could not estop Defendants from following the statutory directive that CHCS receive the reasonable costs of services it provided under Medicare.

Conclusion

For the reasons delineated above, I recommend that the Court GRANT Defendants= Motion for Summary Judgment and DENY Plaintiff=s Motion for Summary Judgment.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. ' 636(b)(1)(B) (1988) for which *de novo* review by the district court is sought, together with a supporting memorandum, within ten (10) days of being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to *de novo* review by the district court and to appeal the district court's order.

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Margaret J. Kravchuk
United States Magistrate Judge

Dated on: June 22, 2000